Disclosure Statement

Welcome!
Washington psychologists are governed by a Licensing Board under chapter 18.83 RCW. This board is designed to help protect your rights as a patient. Questions or concerns may be directed to the Board at:
Department of Licensing
Division of Professional Licensing
P.O. Box 9649
Olympia, WA 98504
(206) 753-1761

OFFICE POLICIES

- My standard fee is $240.00 for the diagnostic & evaluation session (1st visit), $190.00 for all family/couple therapy sessions, and $170.00 for all individual fifty minute sessions and testing hours. Depositions are at a rate of $500.00 an hour. Written reports are prorated at $200.00 per hour. A reasonable fee will be charged for copies of any records requested by the Client.
- By signing you have read this disclosure statement, you are saying that you understand that if I am subpoenaed or otherwise required to participate in a legal proceeding as a result of providing professional services to you, you will be responsible for paying for all time expended on preparation, transportation, being "available or on call" for testimony, and actual testimony time. This time is billed at the rate of $500 per hour, as is time spent on preparing for and giving a deposition.
- If you are using health insurance, your fee will depend upon your co-pay or the percentage that your health insurance requires you to pay. Please remember that if you have a deductible that has not been met, you will be paying out of pocket until you have met your deductible. Payment at the time of services is expected. A bill will not be sent to you. I will be able to furnish you with a receipt for your payment.
- Due to the nature of my work schedule, I am often not immediately available by telephone. You may leave me a confidential voice mail message at (253)569-7698. I will make every effort to return your call on the same day with exception of weekends, holidays, and vacations. In the event of an emergency, you can call the Crisis Line at (800) 427-4747 or go to the nearest hospital emergency room.
- If you do not cancel any appointment **AT LEAST 48 BUSINESS HOURS IN ADVANCE, YOU MAY BE CHARGED FOR THE FULL SESSION FEE OF $170.00. Insurance companies do NOT pay for missed or late cancellation sessions, so you are responsible for the full amount.**

As my client you are entitled to certain specific rights under this law:

1. You may request a change of therapy, referral to another therapist, or to discontinue therapy. I only ask that you discuss these changes with me in person.
2. You are entitled to confidentiality in your communications with me, and with the below noted exceptions. This means that I will need an information release form signed by you before communicating with anyone about your case or even the fact that you have come for therapy, unless one of the exception applies.
   Under Washington state law, clients age 13 and over have the right to confidentiality.

Exceptions to confidentiality: I am legally obligated to take appropriate action in the following cases:

a. If you or your dependent child appears to be at risk of endangering yourself or someone else.
b. If you indicate that you intend to commit a felony.
c. If there is a suspicion of child abuse or neglect, of a physical or sexual nature.
d. If there is a suspicion of abuse or neglect of a dependent or vulnerable adult) an adult who is not able, either physically or mentally, to care for him or herself).

In case of suspected abuse or neglect, I must report this to the Department of Social and Health Services. I prefer working with the patient in making this report, helping the Department to take a fair and minimally disruptive approach based on full information.

Additionally, some disclosure of otherwise confidential information may be required by:

e. The release of necessary medical information for insurance reimbursement purposes. I authorize the payment of medical benefits to the provider of services.
f. Some court subpoenas may require disclosure.
g. In the event that another health care provider (your family physician, for example) has reasonable need for information regarding your general health condition, I am permitted by law to disclose that you are or have been a patient of mine and to relay information regarding your care if it assists that health care provider in delivering appropriate services for you.
h. I may occasionally find it helpful to consult with health and mental health professionals about a case. If I consult with a professional who is not involved with your treatment, I make every effort to avoid revealing your identity. These professionals are legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel that it is important to our work together; however, I will note all consultations in your Clinical Record.
i. I understand that, in the event of the death or incapacitation of my doctor, it will be necessary for another therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by my doctor, to

take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

Without your consent or Authorization, I may disclose information in the following situations:

j. If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.
k. If you file a worker's compensation claim, and the services I am providing are relevant to the injury for which the claim was made, I may be required to release information related to your employer and the Department of Labor and Industries.

3. You are entitled to know essential information about my professional training and orientation. Please feel free to ask additional questions, if you wish. I received my Ph.D. in Clinical Psychology in 1991 from California School of Professional Psychology, San Diego. I have been employed in both inpatient and outpatient settings. I have worked in private practice for 30 years. I work with adolescents, adults, and couples. My license number is #1953.

4. I assist my patients in exploring current problems in the context of their social system (relationships, family, employment and life circumstances). During treatment, I take an integrative, eclectic approach to therapy and draw on a number of different therapeutic approaches (primarily Jungian, Interpersonal, and Cognitive-Behavioral therapies) with the understanding that for you to gain the most benefit from therapy it is important for me to tailor my approach to meet your individual needs and concerns. Normally, I conduct an initial evaluation that will last from 1-3 sessions. During this time, we can decide if I am the best person to provide the services that will help you to meet your treatment goals. In addition to face-to-face sessions, I may utilize psychological tests to facilitate my understanding of your concerns. At the conclusion of the evaluation phase, I will discuss treatment recommendations with you, including the estimated length of treatment. Diagnoses and assessments are professional opinions based on training and experience.

5. **Risks and Benefits**: Psychotherapy is beneficial, but as with any treatment, there are inherent risks. During therapy, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of therapy can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reducing feelings of emotional distress, improved quality of life, and specific problem solving. I cannot guarantee these benefits, of course. It is my desire, however, to work with you to attain your personal goals for psychotherapy. My services are designed to provide you with an integrated solution for your mind, body, spirit and life in order to enhance your life and resolve issues.

Consent to Treatment

I hereby consent to treatment by Mary Galaszewski, Ph.D. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.

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Client/Guardian signature **Date**

Disclosure Statement

Your signature below indicates that you have read, understood, and agree to the terms described in the Disclosure statement. I look forward to working with you and I trust that you will feel free to ask any questions you may have.

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Client/Guardian signature **Date**